Personal History Adult

Client's Name:______________________________

Gender: ___F ____M   Date of Birth:_____________   Age:________

Address:_________________________   City:_________________ Zip____________

Phone (Hm):___________________   Cell:__________________

If you need any more space for any question, please use the back of the sheet.

Primary reason(s) for seeking services:

☐ Anger management   ☐ Anxiety/Depression
☐ Eating Disorder   ☐ Fear/phobia   ☐ Health concern
☐ Sexual concerns   ☐ Addictive behaviors   ☐ Alcohol/drugs
☐ Social skill deficits   ☐ Attention Deficits   ☐ Cope with Stress
☐ Marital Issues   ☐ Parenting

____

____

____

Recent Stressors

☐ Finances   ☐ Housing   ☐ Conflict   ☐ Work
☐ Losses   ☐ Medical   ☐ Transitions   ☐ Legal

Current Health

Medication Name   Dosage   How many times a day?

____

____

____

____

Any chronic pain? ☐ Y   ☐ N

Any chronic disease/condition?____

Family Information

Relationship	Living Y	Living N	Living with you W	Living with you L
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Spouse	☐	☐	☐	☐
Children	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐		
	☐	☐	#Children	

Marital Status (more than one answer may apply)

☐ Single ☐ Divorce in progress

☐ unmarried living together Length of time:______

☐ Legally married Length of time:______

☐ Widowed Length of time:_____

Total number of marriages: ________

Assessment of current relationship: ☐ Good ☐ Fair ☐ Poor

Parental Information:

☐ Parents legally married ☐ Mother remarried: Number of times _____

Parents have been separated ☐ ☐ Father remarried: Number of times ____

Special Circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.) ____________________________________

____

Development

Are there special, unusual, or traumatic circumstances that affected your development?
☐ yes ☐ no . If Yes, please describe: ____________________________________

____

History of child abuse? ☐ yes ☐ no
If yes, which type(s)? ☐ sexual ☐ physical ☐ verbal
If yes, the abuse was as a : ☐ victim ☐ perpetrator

Other childhood issues: ☐ neglect ☐ inadequate nutrition ☐ Other Please explain: ____

Chemical Use History

#

Alcohol 6 or Daily Marijuana Yearly

Other Substance Use (List substance and frequency) ______________________________________

____

Social Relationships

Check how you generally get along with other people: (check all that apply)

☐ Affectionate ☐ Aggressive ☐ Avoidant ☐ Fight/argue
☐ Follower ☐ Friendly ☐ Leader ☐ Outgoing
☐ Shy/withdrawn ☐ Submissive ☐ Other: ______________________________

Sexual dysfunctions? ☐ yes ☐ no If yes, describe: ________________________

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? ____________________

Spiritual/Religious

How important to you are spiritual matters? ☐ Not ☐ Little ☐ Moderate ☐ Very

Are you affiliated with a spiritual or religious group? ☐ Yes ☐ No

If yes, describe: __________________________________

Would you like your spiritual beliefs incorporated into the therapy? ☐ Yes ☐ No

Legal

Are you involved in any active cases (traffic, civil, criminal)? ☐ Yes ☐ No

If yes, please describe and indicate the court and hearing/trial dates and charges:

____

Are you presently on probation or parole? ☐ Yes ☐ No

If yes, please describe: ____

Past History

Traffic violations ☐ Y ☐ N DWI, DUI, etc.: ☐ Y ☐ N

Criminal Involvement: ☐ Y ☐ N Civil involvement: ☐ Y ☐ N

If you responded Yes to any of the above please fill in the following: ____________________

____

Charges	Date	Where(city)	Results

Education

Fill in all that apply: Years of education ________ Currently enrolled? ☐ Y ___N

☐ High school/GED

☐ Vocational: Number of years:_____Graduated: ☐ Y ☐ N Major:_______________

☐ College: Number of years:_____Graduated: ☐ Y ☐ N Major:_______________

☐ Graduate: Number of years:_____Graduated: ☐ Y ☐ N Major:_______________

Other training:____

Special Circumstances (learning disabilities, gifted):__________________________________

Employment

Begin with most recent job history:

Employer	Dates	Title	Reason Left	How often absent

Personal Strengths

Please share your virtues and strengths: ____

____

____

Have you been in therapy before? W☐ N ☐ If yes, why did it end? What was helpful?

____

____

Do you have a Psychiatrist? Please List name and contact information.

If you were referred by your primary care doctor, Please list their name and address.

May I thank the Doctor listed above? ☐ yes. ☐ no

May I include my initial summary of diagnosis/plan? ☐ yes ☐ no

Signature of Client/Parent/Guardian

Date